# Healing Path
## Integrative Medicine, PLLC
### Anne Walch, MHS, PA-C

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# Patient Registration Form

Date: _____ Age ____ Birth Date _____ Gender M | F

Name _____
First MI Last

Street_____ City _____

State _____ Zip _____ Email: _____

Your Tel contact: Cell _____ Home _____ Work _____

Emergency contact person: _____ Tel: _____

How did you learn about this practice? (circle) Friend | web | another practitioner | other _____

If you want any practitioners to receive a copy of your HPIM consult notes **initial here** _____

If "yes", their Name _____(circle: MD | DO | DC | NP | PA | Lac | ____)

Their Fax (preferred mode) _____ Phone _____

Address _____ City _____ State ____ Zip _____

**Are you on Medicaid or Medicare?** Yes / No (See HPIM policy re Medicare/Medicaid patients)

If you have insurance, what company? _____

Your Pharmacy name, fax, phone _____

**Consent to Treat:**

The information that I have given to Healing Path Integrative Medicine is complete and true to the best of my knowledge. I authorize the doctors and staff of HPIM to administer such procedures and treatment as they deem necessary and that I find agreeable. I understand that HPIM implies no guarantees of cure, that I have the right to choose my treatment plan, and that I may refuse any or all treatment suggestions at any time. I acknowledge that I have been given no guarantees or warranties, expressed or implied, regarding the outcome of these procedures. I acknowledge that I have not been asked to discontinue care provided by any specialists or my primary care physician. I understand that these are widely-used and accepted therapies among Integrative Health Practitioners, but are not considered mainstream therapies among conventional physicians. Healing Path Integrative Medicine reserves the right to discharge patients from service at any time with a thirty day written notification. Failure to follow medical advice may result in immediate termination of treatment and possible discharge from the practice.

Name printed _____

**SIGNATURE** _____ Date _____

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## Practitioner-Patient Arbitration Agreement

In the event a dispute shall arise between the parties to this contract, prior to any legal action, the parties agree to participate in at least four hours of mediation in accordance with the mediation procedures of the State of North Carolina. The parties agree to share equally in the costs of the mediation. The mediation shall be administered by a Buncombe County arbitrator. Mediation involves each side of a dispute sitting down with an impartial person, the mediator, to attempt to reach a voluntary settlement. Mediation involves no formal court procedures or rules of evidence, and the mediator does not have the power to render a binding decision or force an agreement on the parties. I have read and understand the policies set forth above.

Name printed: _____

**SIGNATURE**: _____ Date: _____

Practitioner Signature: _____ Date: _____

## Primary Care Understanding

I understand that although Healing Path Integrative Medicine (HPIM) will offer me some services that are typically regarded as "primary care", HPIM is a part-time practice specializing in integrative medicine consultations. HPIM does not have an "on-call" practitioner and are not available for medical emergencies outside of office hours. I will maintain my relationship with my primary care provider or will consider establishing with one if I don't currently have a primary care provider.

Current Primary Practitioner: _____ (MD | DO | DC | ND | PA | NP | Lac. | ___ )

Their street, city, state, zip: _____

Their Phone #: _____ Fax#: _____

Name printed: _____

**SIGNATURE:** _____ Date: _____

## HPIM Policy Understanding

I have read and understand Healing Path Integrative Medicine policies; I've had any of my questions about the policies clarified; I agree to abide by these policies.

SIGNATURE_____Date_____

## HIPAA Notice of Privacy Policies

I have been provided with access [via HPIM website, and hard copy at office] to the HIPAA privacy practices of HPIM that informs me of my privacy rights with respect to my personal health information.

SIGNATURE_____Date_____